ROME
MEMORIAL HOSPITAL
Total commitment. Total care.

1500 North James Street
Rome, New York 13440

Dear Intern Applicant:

Thank you for your interest in interning at Rome Memorial Hospital. We have opportunities for interns in both clinical and non-clinical areas. If you are interning for college credits or mandatory hours, a Student Affiliation Agreement and Certificate of Insurance from your institution will be required.

The NYS Health Department requires that we have the following health information on file for all Interns. You are required to provide this to us.

1. Your immunization records showing that you have had two shots for Measles, Mumps, and Rubella (MMR), or if you were born before 1956, proof of immunity to Rubella. (1 immunization or a blood test).
2. A copy of a physical done within one year.
3. A mantoux (TB) test done within a year.

I have enclosed a copy of our intern application. When the above information is completed, please you may fax, mail or email the application to me. If you have questions, please do not hesitate to contact me through my contact information below.

Sincerely,

Juliana H. Chrysler, M.Ed
Volunteer Coordinator/Community Health Educator
Rome Memorial Hospital
Education Department
1500 N. James Street
Rome, NY 13440

Phone: 315/338-7134 Fax: 315/338-7526
Email: jchrysler@romehospital.org

12/11

Intern Application

Name ___________________________ Date of Birth ______________________

Address___________________________ College attending __________________

___________________________ Major in College_____________________

Telephone #______________________ Cell phone # _____________________

Email Address: ____

Person to notify in case of an emergency

Name:_______________________________________ Relationship_________________

Telephone #_____________________________

Have you ever been convicted of a felony? ____________________________________

Were you referred to us by anyone? ____

Why would you like to intern here? ____

The department / area of assignment desired:

____

Please circle days you wish to do internship: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Hours of the day you wish to do your internship: _________________________________

Please list your college intern coordinator/advisor/contact person:

Name________________________________Title__________________________

Address____

Phone number/ email address____

Do you have any special needs we should be aware of in order to accommodate you in your internship status? Yes ______ No ______

If yes, please explain____

References:

Name ____________________________
Address ___________________________
____

Telephone _______________________
Email ____________________________

Name ____________________________
Address ___________________________
____

Telephone _______________________
Email ____________________________

In signing this application, I confirm the above information is true to the best of my knowledge and ability.

_________________________________ _________________________________

Signature Date

Rome Memorial Hospital

Physical Examination Report for Interns

Name: ______________________________

Date of Birth: ____________________ **Date of Examination:** ____________________

Ht. ______________ **Wt:** ______________ **B/P:** ______________

Vision: ______________ **Left:** ______________ **Right:** ______________

Immunizations: **MMR: 1** ______________ **2** ______________

______ **(TB)** **Mantoux** ______________ **Results** ______________

Influenza Vaccine date: ____________________

Review of Systems:

Eyes __________ **Ears** __________ **Nose** __________ **Throat** __________

Teeth/Gums __________ **Cardiac** __________ **Lungs** __________

GI __________ **GU** __________ **Skin** __________

Musculoskeletal __________ **Nutrition** __________ **Nervous System** __________

Other: ______________________________

____

Medications: ______________________________

Limitations: ______________________________

Diagnosis: ______________________________

Summary: I have examined the patient and found him/her ___able ___unable to participate in volunteer activities at Rome Memorial Hospital. He/she is free of communicable diseases and addictions to drugs/alcohol.

______________________ ______________________

Signature **Date**